PARENTAL CONSENT FOR SERVICE
ADOLESCENT HEALTH PROGRAM

I, _____ parent/legal guardian of _____ request that the Catawba County Health Department and health care providers* designated by the Catawba County Health Department provide or arrange services to meet the needs of my child. These services may include, as necessary and available, any or all of the following:

1. Medical evaluation, including history, physical examination, and routine office laboratory tests.
2. Treatment of injuries and illness, including any necessary prescriptions.
3. Counseling, assessment, consultation, and referral to appropriate services.
4. Substance abuse prevention and intervention.
5. Pregnancy and prevention counseling.
6. Immunizations.
7. Social work services (when available) or referral.
8. Gynecological services and education.
9. Administration of selected prescription and non-prescription medications.
10. Nutritional guidance.
11. Mental Health Counseling and education (individual and/or group), when available.

*Health care providers may include physicians, physician assistants, nurse practitioners, registered nurses, lab technicians, nursing assistants, social workers, counselors, and therapists, all of whom are licensed, certified, or registered and have professional credentials to perform specified assessments and treatments.

Confidential Services

I understand that North Carolina General Statute 90-21.5 protects a minor's right to receive services relating to sexually-transmitted diseases, pregnancy, drug abuse, and emotional disturbance without parental consent. I understand that medical providers are not allowed to notify me about services provided in these areas unless the situation, in the opinion of the medical provider, indicates that notification is essential to the life or health of the minor. I further understand that the Catawba County Health Department will make every effort to encourage my child to discuss problems and services with me.

I have received a copy of the Catawba County Health Department document called *Your Rights and Duties*, understand them, and agree to adhere to all items.

For services not designated as confidential, I understand that I will be informed and will be asked to authorize my child's treatments other than medical or over-the-counter treatments. In the event my child requires urgent medical care and I cannot be reached, I request that my child be allowed to authorize his/her own care with the understanding that I will be contacted as soon as possible. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL ASPECTS OF MEDICAL CARE IF FOLLOW-UP OR REFERRAL TO ANOTHER PROVIDER IS RECOMMENDED.

Access of Services 24 hours a day / 7 days a week

The Catawba County Adolescent Health Program operates 8:00 a.m. to 5:00 p.m. Monday through Friday. I understand that if my child has a life threatening emergency, I am to go directly to the emergency room. If my child's problem is urgent and can not wait until the office reopens, I can reach a health provider by calling 695-5151 or 322-2550 after hours.

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Medical Records Confidentiality

I give permission for information in case records to be shared with my primary care provider (if other than the Catawba County Health Department) in order to coordinate care. I give permission for information in case records to be used for billing third party payors, such as Medicaid or other insurance and for program management and evaluation purposes on a strictly confidential basis in accordance with the law and acceptable medical practice. In order to protect the confidentiality of the services provided through the Adolescent Health Program of the Catawba County Health Department, I request that my child's record be kept confidential and not be released, except as authorized above, to me or anyone else without my child's consent. I understand that my child's record is the property of the Catawba County Health Department and that the information within will be confidential in accordance with state laws and accepted medical practice. I authorize payment of medical benefits to the Catawba County Health Department or other designated agency. I understand that I will not be denied services based on my inability to pay and that I have been offered the opportunity to meet with an Eligibility Specialist to see if our family will qualify for discounted services.

I understand the services and confidentiality policy and agree to abide by all aspects of it. I have received a copy of the North Carolina General Statute 90-21.5, an Act to Authorize Health Services for Minors.

_____ _____ _____

Signature of **Parent / Legal Guardian** **Date of Birth** **Date signed (expires 1 year from date)**

_____ _____

Parent / Legal Guardian **ADDRESS** **Phone Number**

_____/____/_____ _____/____/___

Signature of **Adolescent / Patient** **Date** Signature of **Witness** **Date**

PROVIDER INFORMATION

Name of last doctor or clinic your child was seen in: _____

Address: _____

City: _____ State: _____ Phone: _____

Date last seen:_____ Last Physical Exam:_____ Last Dental Exam:_____

What is your usual source of medical care:

No regular source _____
Emergency room _____
Physician / Clinic _____

INSURANCE INFORMATION

Is your child covered by Medicaid? NO YES ID# _____

Is your child covered by Health Choice? NO YES ID# _____

Is your child covered by other health insurance NO YES

Insurance Company: _____

Insured's Name: _____ Social Security Number: _____

Insured's Employer: _____ Insured's Date of Birth: _____

CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION
Catawba County Health Department

I, _____, hereby authorize the Catawba County Health Department members and their affiliated agencies to exchange confidential information concerning me/my child _____ for the purpose of planning and coordinating appropriate support services.

This information shall include, but is not limited to:

- reason for referral
- any psychological/psychiatric, social, or medical information affecting my/my child's current functioning
- psychological/psychiatric evaluation results
- medication prescribed
- school academic achievement and behavior
- any other information that is pertinent to my/my child's physical, emotional, and educational well being

I understand that the information exchanged will be used only in the best interest of my child. I also understand that I may limit or withdraw this consent at any time in writing, thereby prohibiting any future exchange of information. This consent is valid for a period of one year from the date signed.

I fully understand this authorization, have had any questions answered, and without hesitation consent to the exchange of confidential information.

SIGNED: _____ _____
(signature of parent / guardian) (relationship to child / patient)

_____ _____
(signature of patient) (today's date) (expires in 1 year)

_____
(witness)